

Santa Rosa County Sheriff's Office



Santa Rosa County Sheriff's Office
Sheriff Bob Johnson



CITIZEN COMPLAINT

SI #17-020

Please Print

Date and time of this complaint: 1515 Hrs 3-15-17 Jet. 28 2017 Incident #: 170 24817

Reference Complaint #: 17002110 Deputy Taking Complaint: LT. FREEMANN ID#: 389

Complainant: JOSEPHINE C WEBER
First Middle Last

Address: 2708 CREEKS EDGE, FL 3254
Street City State Zip Code

Home Phone: 936 1297 Work Phone: Cell Phone:

Date and time incident occurred: 1100 Hrs 3-01-17

Location/Address of occurrence: 2708 CREEKS edge to Baptist

Employee(s) involved in allegations(s): DEPUTY SWANTZ, SGT VAUGHN

Witness: None
Name Street Address City/State Home Phone Work Phone

(List additional witnesses in narrative.)

Nature of Allegation(s): My State went to a person
was nothing to do w/ suicide!
Schackole w/ ARMS behind me
I told them I had shoulder
& hip/arm problem. & not
HAND cuff me Rphine - I
BELLED - took me to Baptist
to Baker Act me - THE GIRL
where very nice to me - I tell
them w/ others - that is
what I do - Help Others
NO REASON to BAKER ACT ME
I DID NOT + NEVER SAY
THING ABOUT suicide

Santa Rosa County Sheriff's Office

Findings: _____

Actions Taken: _____

Final Clearance:

<input type="checkbox"/> Exonerated	Proper conduct, An incident occurred as described, but the member was found not to be negligent or at fault.
<input type="checkbox"/> Sustained	(Improper Conduct): The investigation revealed sufficient facts that the allegation(s) were found to be true.
<input type="checkbox"/> Not Sustained	The investigation discloses insufficient evidence to clearly prove or disprove the allegation.
<input type="checkbox"/> Unfounded	The investigation revealed sufficient facts to indicate that the incident did not occur.
<input type="checkbox"/> Partially Sustained	The incident has two or more allegations, and at least one of the allegations is sustained.
<input type="checkbox"/> Violation not based on original Complaint:	Investigation discloses violation(s) not mentioned in the initial allegation.

Complaint Notification of Findings:

Date: _____ By: _____

Comments: _____

☐ Please check here if the complainant refuses to have personal contact by a deputy.

I do hereby affirm that the information provided by me is true and complete to the best of my knowledge and belief. I understand That any false, misleading or untrue statements, accusations of allegations, herein made by me, either orally or in writing, to any person(s) investigating this complaint, may subject me to civil and/or criminal liability under Florida State Statute 837.06, "Whoever knowingly makes false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree punishable by a definite term of imprisonment not exceeding 60 days and a fine of \$500.00."

"Any person who is a participant in an internal investigation, including the complainant, the subject of the investigation, the investigator conducting the investigation and any witnesses in the investigation, who willfully disclose any information obtained pursuant to the agency's investigation, including, but not limited to the identity of the deputy under investigation, the nature of the questions asked, information revealed or documents furnished in connection with a confidential internal investigation or any agency before such complaint, document, action or proceeding becomes public record as provided in the section, commits a misdemeanor of the first degree, punishable as provided in F.S.S. 775.082 or F.S.S. 775.083." Florida State Statute 112.533 (Penalty: up to 1 year in jail and/or up to \$1000.00 fine)

I hereby acknowledge that I have read the preceding and understand its provisions.

Signed: _____

Sworn to and subscribed before me this _____ day of _____, 20 _____

Witness: _____

(Per F.S.S. 117.10)

Santa Rosa County Sheriff's Office

MRI, WRIST, W/ CONTRAST for WEBER, JOSEPHINE 08/25/1940 (76yo F) #60324710
E#60324710

Ordering Provider	Brian Perez, MD	Performing facility	SACRED HEART HOSPITAL (RADIOLOGY-SCHEDULING)
Reported Date		Accession ID	
Performed Date	03/14/2017 00:00		

03/14/2017 10:54AM

Institute of Diagnostic Imaging

No. 0050; #11P. 6 Page 1 of 1



Institute of
Diagnostic
Imaging

424 Racetrack Road NW
Fort Walton Beach, FL 32547
850-314-7575

Handwritten signature

Handwritten signature

IMAGING REPORT

Patient Name: WEBER, JOSEPHINE C.
MR#: 58527
Exam Date: 03/14/2017

Birth Date: 08/25/1940
Age: 76
Referring Physician: BRIAN PEREZ MD
CC Physician:

Exam(s): MRI Upper Extremity Joint without contrast (Right side) (Wrist)

HISTORY: 76-year-old patient with recent reported right wrist and proximal forearm pain following handcuffing trauma.

TECHNIQUE: This examination of the right wrist is performed on a high field 1.5 Tesla GE magnet and utilized to acquire a series of sagittal, axial, and coronal imaging including T1, fat suppressed proton density, T2, and STIR sequences through the right wrist and distal forearm.

FINDINGS: Given the history of trauma, there is no evidence of fracture identified. The abnormal findings include edema at the triangular fibrocartilage which is nonetheless grossly intact except for the radial attachment where there is mild edema in coronal image #7 of the fat suppressed proton density sequences. There is also fluid in the distal radioulnar joint consistent with some triangular fibrocartilage injury at this level, seen on coronal image #8. There is minimal radiocarpal and midcarpal joint space fluid and osteoarthropathy that includes also the base of the right thumb at the carpometacarpal joint. Predominant fluid is seen on the ulnar aspect of the wrist, however, but the ulnar collateral ligament is intact as is the radial collateral ligament. The T1 exams show a low signal intensity process extending across the head of the carpal navicular and a similar finding is seen on the transverse images traversing the head of the ulna at the level of the distal radioulnar joint in image #17 of the transverse images. Given the mechanism of injury submitted, these are more likely contusions rather than actual fractures, transcortical, but both findings are definite with acute edema seen on the relative T2 weighted images with fat suppression. No similar features are seen of the distal radius and ulna shafts otherwise. There is some minimal similar subchondral edematous change seen also of the body of the hamate and the base of the capitate in transverse image #10. The proximal metacarpal exam is negative. The carpal tunnel is negative. The major extensor and flexor tendon sheaths are normal. No substantial ligamentous disruption is seen in the transverse images.

IMPRESSION:

1. MULTIFOCAL BONY CONTUSIONS OF THE CARPAL NAVICULAR AND RADIAL SURFACE OF THE DISTAL ULNAR HEAD AT THE DISTAL RADIOULNAR JOINT.
2. SOME MINIMAL SUBCHONDRAL EDEMA IS ALSO SEEN AT THE VOLAR INTERCARPAL SURFACES OF THE HAMATE AND CAPITATE.
3. NO STRUCTURAL LESION IS SEEN SUCH AS A TRANSCORTICAL FRACTURE TO INCLUDE DISTAL RIGHT FOREARM AND THE RIGHT CARPAL ELEMENTS AND METACARPAL STRUCTURES WHERE VISUALIZED.
4. CARPAL TUNNEL IS INTACT AS ARE THE MAJOR TENDONS.
5. ADDITIONAL INJURIES SEEN OF UNCERTAIN ACUITY, BUT MORE LIKELY ACUTE THAN CHRONIC INCLUDE THE ULNAR ATTACHMENT TRIANGULAR FIBROCARILAGE, FLUID IN ALL THREE OF THE RIGHT WRIST CARPAL SPACES, INCLUDING THE DISTAL RADIOULNAR JOINT, AND CHRONIC OSTEOARTHROPATHY BASE OF THE RIGHT THUMB.

Interpreted By: Barry Riggs

Electronically Signed By: Barry F Riggs

Transcribed by: amli3 / Date Transcribed: 03/14/2017

WEBER, J 08/25/40 #60324710 MRI, W



* 51316750w9582 Single Page ImgReet

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SANTA ROSA COUNTY SHERIFFS OFFICE

5755 EAST MILTON RD
MILTON, FL 32583
(850)983-1216

SUPPLEMENT NUMBER 1

OFFENSE REPORT

Agency Case Number SRSO17OFF002110	Report Date / Time 03/01/2017 02:39 PM	Offense Description 13-0 BAKER ACT
CAD Incident Number SRSO17CAD024817	External Case Reference Number	Range of Occurrence Date/Time 03/01/2017 11:01 AM to 03/01/2017 11:01 AM

LOCATION OF OCCURRENCE

County SANTA ROSA	Address 2708 CREEKS EDGE LN , NAVARRE, FL 32566	Latitude 30.4336	Longitude -86.92094
Location Category Residence	Location Type Victim's residence	Location Description SINGLE FAMILY RESIDENCE	Location Status Inhabited
Weather <input type="checkbox"/> Clear <input checked="" type="checkbox"/> Cloudy <input type="checkbox"/> Fog <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> Hail <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Lighting Condition Lights on	

PERSON: VICTIM

First Name JOSEPHINE	Middle Name COLLINS	Last Name WEBER	Suffix	Date of Birth 08/25/1940	Age 76	Race W	Sex F	Height 5'05"	Weight 120	Hair WHT	Eyes HAZ
Master Name Index Number SRSO00MNI011020	Place of Birth	Nation UNITED STATES	Driver's License or Other ID W160423408050		State FL	Class or Type E					
Address 2708 CREEKS EDGE LN		City NAVARRE	County SANTA ROSA		State FL	Zip Code 32566	Phone (850)936-1297				
Residence Status Within jurisdiction		Vehicle on Report Associated with Person				<input type="checkbox"/> Arrested <input type="checkbox"/> Wanted					
Occupation RETIRED		Employer RETIRED		Master Business Index Number							
Address		City	State	Zip Code	Phone						

CHARGES

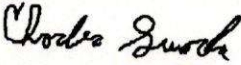
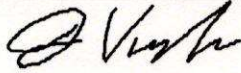
Counts 1	Charge Number 777.77	Charge INFORMATION ONLY
Charge Degree	Charge Level	General Offense Code NOT APPLICABLE
		<input type="checkbox"/> Hate Crime <input type="checkbox"/> Domestic Violence
Charge Description INFORMATION ONLY		

INITIAL NARRATIVE: 03/01/2017 02:44 PM

Reporting Officer		Approving Supervisor	
Call Number 157	Officer Name SWARTZ, CHARLES EDWA	Permanent ID Number SRSO15PER000005	Approved <input checked="" type="checkbox"/>
		Supervisor Name VAUGHN, JAMES ROBERT	Permanent ID Number SRSO05PER000099

On the above date and approximate time, I responded to the above incident location in reference to reported suicide threats. Dispatch advised the victim, Josephine Weber, called an AT&T call center and advised the call taker that she wanted to overdose because she "didn't want to be here anymore". Upon arrival, I made contact with and interviewed the victim, who during the interview stated to me "I just want to go to sleep and never wake up" and "I just want to die, I don't want to live anymore". I knew the victim suffered from mental illness from prior encounters with her, and during this incident she displayed signs of depression and extreme obsessive/compulsive behavior. The victim is also prescribed narcotic medications. I determined based on these facts the victim met baker act criteria. The victim attempted to resist Deputy Sgt. J. Vaughn #042 and my efforts to handcuff her and escort her to my vehicle, but we were able to overcome her efforts without use of force. The victim further displayed signs of mental illness by demanding that I rub her feet due to a foot cramp. Once in the car, she also threatened to break my arm and to sue me for police brutality. The victim requested her neighbor, Zoe Johnson of 2704 Creeks Edge Ln, assist in securing her home, which she did per the victim's instructions. I then transported the victim to Baptist Hospital Emergency Room/Behavioral Health Unit without further incident. The victim's purse, keys, cell phone, checkbook, glasses, and day planner were taken with her to the hospital and given to the staff. I have no further information or involvement in this case at this time. This report is for information only; no crime occurred. This incident occurred within Santa Rosa County, Florida.

REPORTING OFFICER / SUPERVISOR APPROVAL

Reporting Officer		Approving Supervisor	
Call Number 157	Name SWARTZ, CHARLES EDWA	ID Number 831	Rank LE DEPUTY
Signature 		Name VAUGHN, JAMES ROBERT	
		Signature 	

Rights of Persons In Mental Health Facilities and Programs (page 2)

*Went to me
on out talk
was denied my
rights not to stay
here*

Informed Consent

Before any treatment is given to you, you will be given information about the proposed treatment, the purpose of the treatment, the common side effects of medication you receive, alternative treatments, the approximate length of care, and that any consent given may be revoked at any time by you, your guardian your guardian advocate, or your health care surrogate/proxy. There are additional disclosures that must be made for medications you receive. If the treatment for which you have given consent is changed at any time during your stay in this facility, it will be fully explained by the staff prior to asking for your written consent to the revised treatment.

Clothing and Personal Effects

You have the right to keep your clothing and personal effects unless they are removed for safety or medical reasons. If they are taken from you, an inventory of the possessions will be prepared and given to you to sign. The possessions will be immediately returned to you or your representative upon your discharge or transfer from this facility.

⑥ Habeas Corpus

You or your representative has the right to ask the Court to review the cause and legality of your detention in this facility or if you believe you have been unjustly denied a legal right or privilege or an authorized procedure is being abused. A petition form will be given to you by staff upon your request. If you wish to file a habeas corpus petition, you can submit it to a facility staff member, and it will be filed with the court for you by the facility no later than the next court working day.

*OFFICE LIVE IN SANTA ROSA
? IS THIS WHY HE BROUGHT
ME TO PENSACOLA? 20?*

Voting

You have the right to register to vote and to cast your vote in any elections unless the court has removed this right from you. Staff will assist you in arranging for registration or voting.

Discharge

You have the right to seek treatment from the professional or agency of your choice after your discharge from this facility.

Person's Signature _____

Signature, if applicable, of ☐ Guardian ☐ Guardian Advocate ☐ Representative ☐ Health Care Surrogate/Proxy

Witness Signature _____

The hospital did not provide this for me with take only check & initials due to show

This form must be retained in the clinical record as a receipt that the person received notice of his/her rights at the time of admission. A copy must be given to the person and to any authorized decision-maker for persons incompetent or incapacitated by age or disability.

cc: Check when applicable and initial/date/time when copy provided

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input type="checkbox"/> Person		am pm	
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		a m pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Health Care Surrogate/Proxy		am pm	

Rights of Persons

In Mental Health Facilities and Programs

The following rights are guaranteed to you under Florida law. These will be fully explained to you at the time of and following admission to this facility. A copy of this form will be given to you to keep. You have the right to read the Baker Act law and rules at any time. Your signature on the form, if you choose to sign, only acknowledges that you have had the rights explained and that a copy of this form was provided to you.

Individual Dignity

You have the right to individual dignity and access to all constitutional rights. The federal Americans with Disabilities Act (ADA) applies to persons in this facility.

Right to Request Discharge by Persons on Voluntary Status

If you request discharge, your doctor will be notified and you will be discharged within 24 hours from a designated community facility and within 3 working days from a state hospital, unless you withdraw your request or you meet the criteria for involuntary placement. If you meet the criteria for involuntary inpatient placement or involuntary outpatient placement, the hospital administrator must file a petition with the Court for your continued stay within two (2) working days of your request for discharge.

I DID Request / NOT TOLD I COULD GO

Dub Deputy

Designation of Representative

You will be asked to identify a person to be notified in case of an emergency. Further, if you are at this facility for involuntary examination and do not have a guardian appointed by the court, you will be asked to designate a person of your choice to receive notification of your presence in this facility, unless you request that no notification be made. If you do not or cannot designate a representative, a representative will be selected for you by the facility from a prioritized list of persons. You have the right to be consulted about the person selected by the facility and you can request that such a representative be replaced.

Communication

You have the right to communicate openly and privately by phone, mail, or visitation with persons of your choice during your stay at this facility. You have the right to make free local calls and will be given access to a long distance service for collect calls. If communication is restricted, you will be given a written notice including the reasons for the restrictions. This facility is required to develop reasonable rules governing visitors, visiting hours, and the use of telephones but you cannot be limited in your access to your attorney, to a phone for the purpose of reporting abuse, in contacting the Florida Local Advocacy Council or the Advocacy Center for Persons with Disabilities. Several toll-free telephone numbers you may wish to keep are:

Florida Abuse Registry

1 800 96-ABUSE or (800) 342-9152

Advocacy Center for Persons with Disabilities

1 800 342-0823

Confidentiality of Information and Records

Information about your stay in this facility is confidential and may not be released, except under special circumstances, without your consent (or the consent of your guardian or guardian advocate or health care surrogate/proxy if you have one). Special circumstances include release of information to your attorney, in response to a court order, to an aftercare treatment provider, or after a threat of harm to another person. You have the right of reasonable access to your clinical record unless such access is determined to be harmful to you by your physician.

Treatment

You have the right to receive the least restrictive, available, appropriate treatment in this facility. You will get a physical examination within 24 hours of arrival and you will be asked to help develop a treatment plan to meet your individual needs. The criteria, procedures, and required staff training used by this facility for restraints, seclusion, isolation, emergency treatment orders, close levels of supervision, or physical management are available for your review. Such interventions may never be used for punishment, convenience of staff, or to compensate for inadequate staffing.

Advance Directives

You have the right to prepare an advance directive when competent to do so that specifies the mental health care you want or don't want and to designate a health care surrogate to make those decisions for you at the time of crisis. The facility is required to make reasonable efforts to honor those choices or transfer you to another facility that will honor your choices. The facility must document whether you have an advance directive and inform you of its policies about advance directives. There are organizations that can help you prepare an advance directive.

(Continued Over)



Santa Rosa County Sheriff's Office

Notice of Right to Petition for Writ of Habeas Corpus or for Redress of Grievances

Medical
Records
- Rt -

100 - West Barber -
- BK Amuse -

To: Josephine Lueker

PLEASE BE ADVISED that you may petition the Circuit Court for a Writ of Habeas Corpus to question the cause and legality of your detention. Furthermore, a petition may be filed in the Circuit Court in the county in which you are placed for Redress of Grievances alleging that you are being unjustly denied a right or privilege or that an authorized procedure is being abused.

A Petition for Writ of Habeas Corpus and Redress of Grievances (CF MH Form 3090) may be used for this purpose. A petition must be signed by either you, your relative, friend, guardian, guardian advocate, representative, attorney, or the Department of Children and Families.

Staff of this facility will provide a copy of the Writ form to you immediately upon your request. Staff will assist you in completing this Writ form if you request such help. The Petition for a Writ will be submitted by the staff to the Circuit Court no later than the next working day after you submit the form.

Josephine Lueker
Signature of Administrator or Designee

3-1-17
Date

1800 am pm
Time

This completed form must be given to all persons admitted to a facility and to those individuals listed below as applicable.

I TOLD him at houses he couldn't
put my arms behind me + WHY
due to injury - I SCREAMED IN
PAIN INTENSE TIME

cc: Check when applicable and initial/date/time when copy provided:

Individual	Date Copy Provided	Time Copy Provided	Initials of Who Provided Copy
<input checked="" type="checkbox"/> Person	<u>3-1-17</u>	<u>6</u> am <u>pm</u>	<u>SL</u>
<input type="checkbox"/> Guardian		am pm	
<input type="checkbox"/> Guardian Advocate		am pm	
<input type="checkbox"/> Representative		am pm	
<input type="checkbox"/> Health Care Surrogate/Proxy		am pm	

My WRIST WERE PURPLE - couldn't
get any one BAKER ACT
to write it
down